Maryland Department of Disabilities
Office of Personal Assistance Services
Attendant Care Program

The Maryland Attendant Care Program reimburses eligible persons with disabilities for a portion of their attendant care costs.

To be eligible for the program, YOU MUST:

1. Be a Maryland resident; **and**
2. Be between the ages of 18 and 64; **and**
3. Be determined and certified by your physician to have a severe disability that keeps you from performing essential activities of daily living, self-care, and mobility; **and**
4. Not be receiving duplicative attendant care services; **and**
5. Have a total gross income (taxable and non-taxable) of less than $53,522 per year;

----------AND----------

6. You must be employed; **or**
7. You must be actively seeking employment; **or**
8. You must be enrolled in an institution of post secondary or higher education; **or**
9. You must be a nursing facility resident who would be able to reside in the community if attendant care is provided; **or**
10. You must be at risk of nursing facility placement if you do not receive attendant care services in the community.

To apply for the Attendant Care Program YOU MUST:

1. Complete pages 2-8 of this application packet.
2. Submit all signatures required in this application packet.
3. Submit proof of eligibility where required, as outlined in this application packet.
4. Have your doctor or registered nurse complete pages 9-11 of this application packet.
5. **If you are a designee or authorized representative** for the applicant, you must include proof that you are authorized to apply on the applicant's behalf. See page 7 of this application packet for acceptable forms of proof.

APPLICATION FOR ATTENDANT CARE PROGRAM

SECTION 1: APPLICANT INFORMATION

_____ _____-_____-_____
Name Social Security No.

___/___/_____ _____ (_____)_____-_____ _____
Date of Birth Age Telephone Number Marital Status

_____
Street Address

_____
City County State Zip Code

____ I have enclosed proof of my age (such as a copy of my driver's license or birth certificate) and proof of Maryland residency (such as a copy of my utility or telephone bill).

____ I am currently enrolled in the following program(s):

___ In-Home Aide Services (IHAS)
___ Medicaid Personal Care (MAPC)
___ Medicaid Waiver (Older Adults Waiver or Living at Home Waiver)

____ I am not currently enrolled in any of the above programs.
SKIP TO NEXT BOX

I AM: (Choose all that apply)

____ Currently employed.

____ Currently looking for work.

____ Currently attending an institution of post secondary or higher education.

____ Residing in a nursing facility and able to reside in the community if attendant care is provided.

____ At risk of going into a nursing facility if attendant care services are not received in the community.

____ None of the above.

SECTION 2: CURRENT EMPLOYER INFORMATION

____ Not applicable (I am not currently employed).
SKIP TO NEXT BOX

_____ _____ _____ $_____
My Job Title/Occupation # hrs./week Weekly Salary

_____ ___/___/___ (____)_____-_____
Employer Name Start Date Employer Phone Number

_____
Employer Street Address

_____
City County State Zip Code

SECTION 3: JOB-SEEKING ACTIVITIES

____ Not Applicable (I am not currently looking for a job).
SKIP TO NEXT BOX

____ The following information shows recent attempts I have made to find a job:

____ I have enclosed a copy of my resume.

Date of Contact	**Employer Name and Address**	**Result of Contact**

SECTION 4: NURSING FACILITY INFORMATION

_____ Not applicable (I am not currently living in, nor on a waiting list for placement in, a nursing facility).
SKIP TO NEXT BOX

____ I currently **(circle one)** live in/am on a waiting list for placement in the following nursing facility:

_____ (_____)_____-_____
Nursing Facility Name Facility Telephone Number

_____
Nursing Facility Street Address

_____
City County State Zip Code

SECTION 5: VERIFICATION OF RISK OF NURSING FACILITY PLACEMENT

____ Not applicable (I am not currently at risk of nursing facility placement).
SKIP TO NEXT BOX

____ I have enclosed a signed letter from my physician, on my physician's business letterhead, stating that I am at risk of nursing facility placement if I do not receive attendant care services in the community.

SECTION 6: SCHOOL ENROLLMENT INFORMATION

____ Not Applicable (I am not currently attending an institution of post secondary or higher education).
SKIP TO NEXT BOX

____ I am enrolled in the following post secondary/higher education institution:

_____ _____
Name of Institution Semester enrolled

_____
Address

_____
Declared Major of Study

____ I have enclosed proof of enrollment (a class schedule or letter from the school's registrar office indicating my name, social security number and the dates of enrollment).

SECTION 7: I WOULD LIKE THE FOLLOWING PERSON(S) TO BE MY ATTENDANT:

____ I understand that any attendant I choose must be at least 18 years of age and must not be my spouse, child, stepchild, parent, grandparent, sibling, or in-law.

ATTENDANT 1:

_____ _____
Name Attendant's Relationship to Me

_____/_____/_____ _____ (_____)_____-_____
Date of Birth Age Telephone Number

_____
Street Address

_____
City County State Zip Code

ATTENDANT 2:

_____ _____
Name Attendant's Relationship to Me

_____/_____/_____ _____ (_____)_____-_____
Date of Birth Age Telephone Number

_____
Street Address

_____
City County State Zip Code

ATTENDANT 3:

_____ _____
Name Attendant's Relationship to Me

_____/_____/_____ _____ (_____)_____-_____
Date of Birth Age Telephone Number

_____
Street Address

_____
City County State Zip Code

____ I have not yet chosen an attendant but I understand that any attendant I choose must be at least 18 years of age and must not be my spouse, child, stepchild, parent, grandparent, sibling or in-law.

SECTION 8: MY AND/OR MY SPOUSE'S INCOME WORKSHEET

(A) **Total Taxable Income** from my most recent IRS Tax Form $_____

____ I have attached a copy of my most recent IRS Tax Form.

----------OR----------

(B) **Income Tax Filing Status Declaration**

I, _____, in accordance with the Internal Revenue Service Regulations, am not required to file an Income Tax Return for the year ending December 31, _____, due to insufficient income.

The above statement is accurate to the best of my knowledge.

_____ _____

Applicant's Original Signature Date

(C) Annual Gross Income (Select all that apply)	
____ Social Security Disability Insurance	$
____ Supplemental Security Income	$
____ Workers Compensation	$
____ Public Assistance (Specify) _____	$
____ Veterans Benefits	$
____ Spousal Income	$
____ Other (Specify) _____	$
(D) Total Annual Gross Income (add all sources of income listed above)	$
(E) Allowable Deductions	
____ Monthly Medical Expenses	$

____ I have attached verification of the above income amounts.
____ I have attached verification of monthly medical expenses. (health insurance premiums, medical supplies and/or equipment, prescription costs)

SECTION 9: DEPENDENT INFORMATION

Total Number of Persons Dependent on the Above Income (D) _____
Specify Number (check all that apply):

____ Spouse ____ Number of Dependent Children

____ Parent(s) ____ Other (Specify Relationship)_____

SECTION 10: MY REQUIRED ORIGINAL SIGNATURES

I understand that I must submit original signatures on my application for the Attendant Care Program. This means that the Attendant Care Program will not accept any photocopies or faxes of my application.

I further understand that if a designee or authorized representative is completing and signing my application, I must include, with the application, a notarized letter of consent, court papers, or a Power of Attorney authorizing my designee or representative to apply on my behalf.

I hereby certify that the information contained in this application is true and correct to the best of my knowledge and that, if I am approved for participation in the program, I will immediately report any changes in this information to the Attendant Care Program.

_____ _____

Applicant's Original Signature Date

SECTION 11: FINANCIAL INFORMATION

I hereby certify that the income information I have supplied to the Attendant Care Program is true and correct to the best of my knowledge. I understand that, if I am approved for participation in the program, I will immediately report any change in my income to the Attendant Care Program. I further certify that I am not receiving reimbursement from any other program or agency for paying my attendant care costs.

_____ _____

Applicant's Original Signature Date

SECTION 12: RELEASE OF INFORMATION

I hereby authorize the Maryland Department of Disabilities Attendant Care Program to verify information regarding my application and obtain copies of medical and other documentation to establish my eligibility.

_____ _____

Applicant's Original Signature Date

Attendant Care Program Survey

We request that you voluntarily provide the following information to assist in the future evaluation of the program. All information you provide will remain anonymous.

1. I easily understood the application materials sent to me **(check one)**:
   ___ Agree ___ Disagree

2. The application process was difficult for me to complete:
   ___ Agree ___ Disagree

3. My Gender: ___ Male ___ Female

4. My Ethnic Origin:

   ___ White ___ Black ___ Hispanic ___ Other _____

5. The Highest Level of Education I Completed:

   ___ Less than High School ___ High School/GED ___ Some College

   ___ Associates Degree ___ Bachelors Degree ___ Graduate Degree

   Other Training/Special Skills: _____

6. Type of Job Being Sought: _____

7. Living Arrangement:

Type of Housing:	I live:
___ Single Family Dwelling	___ Alone
___ Congregate Living	___ With other people with disabilities
___ Institution	___ With family members
___ Apartment	___ With another person not specified above
___ Other _____	___ Other _____

8. I found out about the Attendant Care Program through:

   ___Newspaper ___ Doctor or Nurse ___Relative ___Television

   ___ Radio ___ Friend ___Public Agency ___Other _____

STANDARD ASSESSMENT OF FUNCTIONAL CAPABILITY
(TO BE COMPLETED AND SIGNED BY PHYSICIAN OR REGISTERED NURSE)

The Maryland Department of Disabilities administers the Attendant Care Program. This program provides financial reimbursement for attendant care services to eligible individuals with disabilities. This Standard Assessment of Functional Capability is required for individual eligibility determination. Please complete this Standard Assessment of Functional Capability and return to:

Maryland Department of Disabilities
Attendant Care Program
217 East Redwood Street, Suite 1300
Baltimore, Maryland 21202

APPLICANT/PATIENT INFORMATION

_____ _____-_____-_____
Name Social Security No.

_____/_____/_____ _____ (_____)_____-_____
Date of Birth Age Telephone Number

_____
Street Address

_____
City County State Zip Code

PATIENT HEALTH EVALUATION

Medical History (Statement regarding onset of disability, Diagnosis and Prognosis, and any communication limitation)

_____
_____
_____
_____
_____
_____

Date of Initial Visit _____ **Date of Most Recent Visit** _____

ACTIVITIES OF DAILY LIVING		
Client Eats	Client Uses Toilet	Client Walks
2 By self **1** With assistance **0** Must be fed / intravenously / tube fed	**2** By self **1** With supervision **0** Must have complete assistance	**2** By self **1** With assistance from another person **0** Must have complete assistance
Client Transfers to Bed or Chair	Client Travels Beyond Walking Distance	Client Takes Medications
2 By self (or with object) **1** With assistance from another person **0** Must be lifted / bedbound	**2** By self (including public transportation) **1** Needs some assistance / escort **0** Must have complete assistance / specialized vehicle	**2** By self **1** Needs assistance / reminders **0** Must have complete assistance
Client Gets Dressed / Changes Clothes	Client Prepares a Light Meal	Client Handles Own Money
2 By self **1** With assistance **0** Must be dressed	**2** By self **1** With assistance for selected items **0** Must have complete assistance	**2** Writes checks by self, keeps track of funds **1** With assistance, e.g., checkbook, paying bills **0** Must have complete assistance
Client Completes Bathing	Client Does Light Chores	Client Uses Telephone
2 By self **1** With help washing, turning on water, etc **0** Must have bed bath / total assistance	**2** By self **1** With assistance; e.g., making a bed **0** Must have complete assistance	**2** By self **1** With assistance dialing / using directory **0** Cannot make and/or receive calls
Client Completes Grooming	Client Does Grocery Shopping	Client Plans & Makes Decisions
2 By self **1** With help shaving / combing hair **0** Must have complete assistance	**2** By self **1** With assistance/someone to go with **0** Must have complete assistance	**2** By self **1** With assistance **0** Dependent on others to plan / decide

Total ADL Score _____
(Add the numbers circled and enter as the Total ADL Score)

Interpretation: 30 = No Disability 25-29 = Mild Disability
20-24 = Moderate Disability 0-19 = Severe Disability

ESTIMATED HOURLY NEED		
FUNCTION/TASK	**HOURS PER DAY**	**HOURS PER WEEK**
Assistance with Eating		
Routine Bodily Functions (Bowel and Bladder Care)		
Transfers (To and From Bed, Chair, Wheelchair, Automobile)		
Personal Hygiene (Bathing, Dressing, Grooming)		
Household Chores (Laundry, Meal Preparation, Cleaning, Transportation, Grocery Shopping)		
Total Hours		

SPECIFY ANY ADDITIONAL NEEDS OR COMMENTS

_____
_____
_____
_____

PHYSICIAN'S CERTIFICATION

I certify, based on the above Standard Assessment of Functional Capability, that the above named individual has a chronic or permanent disability that precludes or significantly impairs the individual's independent performance of essential activities of daily living, self-care, and mobility.

Please indicate professional designation:

_____ _____
Original Signature of Physician or R.N. Date

Please Print or Type:

_____ (_____)_____-_____
Name of Physician or R.N. Telephone Number

_____
Address